TN Department of Health

Fall 2016

BOARD OF MEDICAL EXAMINERS

ANNUAL NEWSLETTER

Revised Telemedicine Rules Assigned Effective Date of October 31, 2016

Board will no longer issue telemedicine licenses

The first telemedicine license was issued in Tennessee in 1998. At that time, telemedicine was in its infancy, and was commonly defined as the practice of medicine across state lines. When the Board turned its attention to revising its telemedicine rules, it was one of only a handful of states that had retained this definition of telemedicine.

Over a series of meetings spanning a period of almost two years, the Board revised and refined its telemedicine rules to more accurately reflect modern day telemedicine. During the Board's deliberations, a legislative change was enacted which emphasized that telemedicine was the practice of medicine and prohibited telemedicine providers from being held to a stricter standard of care. Pursuant to Tenn. Code Ann. § 63-1-155(c)(1)(A), "A healthcare provider who delivers services through the use of telehealth shall be held to the same standard of professional practice as a similar licensee of the same practice area of specialty that is providing the same healthcare services through in-person encounters."

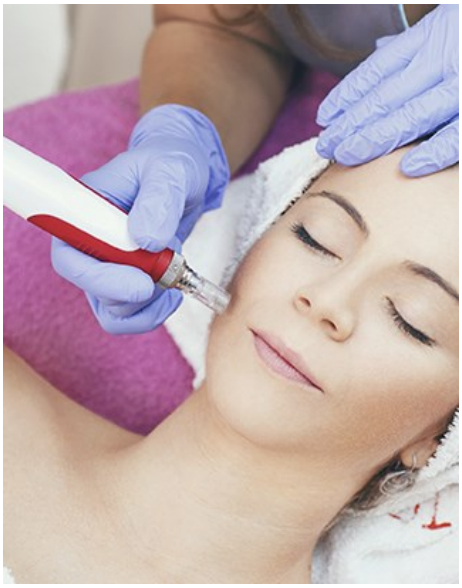
Though this legislative change slowed the progress of the rulemaking process somewhat, it may have also positively impacted the Board's deliberations insofar as it emphasized the Board's existing interest to ensure fairness to all providers. Additionally, the resulting regulations were specific to the medical service being provided rather than the practice setting or mode of delivery. The rule was reviewed by the Joint Government Operations Committee on October 19th, 2016 and became

Continued on page 2

Further Changes to the Board's Medical Spa Registry Coming in January 2017

Pursuant to Public Chapter 494 which was signed by Governor Haslam on May 20th, 2015, the Board of Medical Examiners, in collaboration with the Board of Osteopathic Examination, is required to establish and maintain an online registry for medical spas. The registry was to include, at a minimum, the name and physical address of the medical spa, and the name and medical credential of the medical director or supervising physician(s). The Public Chapter expanded the definition of "medical spa" so that it included physicians' offices for the first time. This meant that any entity providing cosmetic medical services—even a physician's office—was required to register as a medical spa.

Though this legislative change was met with some resistance from the boards' physician licensees, in 2015, the Board's administrative office proceeded with implementation of the change in accordance with the legislative directive of Public Chapter 494.



Med Spa Changes

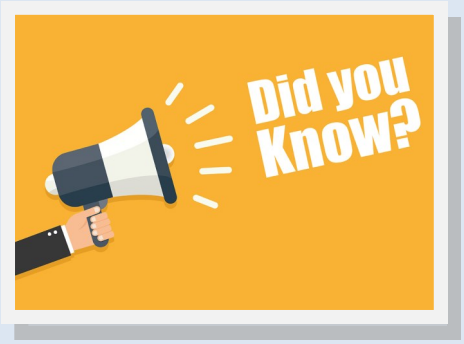
Continued from Page 1

However, in April 2016, Public Chapter 956 was enacted which brought further changes to the med spa registry. The definition of a medical spa was amended again to specify that a physician's office would only be considered a medical spa if the office "advertises or holds itself out as a medical spa" or "primarily engages in the performance of elective cosmetic medical services." "Elective cosmetic medical services" is not defined in the statute.

In summary, after two successive years of legislative activity, the requirement to register as a medical spa only applies to the following entities:

- Non-physician owned offices that provide cosmetic medical services;
- Physician-owned offices that advertise or hold themselves out as a medical spa; and
- Physician-owned offices that primarily engage in the performance of elective cosmetic medical services.

If you are registered as a medical spa, you should have received a letter notifying you of this change and prompting you to take appropriate action. If you have any questions about whether you should register or maintain your current registration, please contact Wilma.Black@tn.gov.



- *Public comments to proposed rules are accepted at all rulemaking hearings?*
- *Tennessee is one of only 15 states that has two medical boards? The Board of Medical Examiners governs the practice of medical doctors while the Board of Osteopathic Examination governs the practice of doctors of osteopathy.*
- *By the time this newsletter is published, there will be more than 22,000 physicians with a current Tennessee medical license?*

Telemedicine Rules

Continued from page 1

effective October 31, 2016.

As of the rule's effective date, the Board will no longer issue telemedicine licenses. All current telemedicine license holders will have the option to keep their license in accordance with certain requirements and restrictions, or convert their telemedicine license to a full and unrestricted medical license. The cost to convert a telemedicine license to a full and unrestricted medical license will be waived so long as the application is received in the Board's administrative office by October 31, 2018.

If you are a telemedicine license holder, you should have received a letter from the Board's administrative office notifying you of your options and providing you with additional information. If you are a Tennessee licensed physician who practices via telemedicine, you can consult the rule on the Board's website. More information will be made available through the Board's website following the rule's effective date.

TN Department of Health

Tennessee Board of Medical Examiners
2nd Floor | 665 Mainstream Drive | Nashville, TN, 37206
T: 615-532-3202 | F: 615-253-4484 | tn.gov/health/topic/ME-board

End of Year Update for Prescribers

A summary of important legislative developments affecting Tennessee prescribers

From Cape Cod to Appalachia; corn fields to concrete city blocks; prescription drug abuse, misuse and diversion is indiscriminately crippling communities across the nation. The Tennessee Department of Health and your licensing board have worked very hard to gain a greater understanding of this complex issue, and in particular, what it is about our citizenry that makes us so vulnerable to abuse. Through partnerships with law enforcement, state and federal agencies, community coalitions, legislators and community leaders, we have developed a multi-year, multi-pronged strategic approach with a focus on educating providers and patients on the risks of opiate use and preventing the recreational use of opioids and other prescription drugs.

Healthcare providers, especially prescribers, have a unique opportunity to combat opioid abuse, misuse and diversion. They may also have a professional obligation to engage in certain activities designed to reduce the supply of opioids available for diversion and increase the information known about at-risk patient populations. Read on to learn more about statutory and policy developments affecting the prescribing practices of Tennessee providers.

Prescription Safety Act of 2016

In April 2016, the Prescription Safety Act (PSA) of 2016 became effective. The PSA was first enacted in 2012 and was scheduled to sunset in 2017. The PSA 2016 eliminated the sunset provision, making the act permanent. While the PSA primarily regulates the prescribing of controlled substances by establishing operational procedures for the controlled substance monitoring database (CSMD), the following revisions to the act may impact providers' prescribing practices directly:

- Dispensers must check the database when dispensing a controlled substance to a new patient.
- Dispensers must check the database at least once a year when an existing patient is on a maintenance medication.
- All prescribers must check the CSMD before prescribing to someone who is exhibiting "drug seeking behavior."
- Prescribers are not required to check the CSMD before writing a prescription for a seven day supply or less.
- Prescribers are not required to check the CSMD before prescribing for administration directly to a patient during the course of inpatient or residential treatment in a licensed hospital or nursing home.

The act authorized many more changes to the operation of the CSMD. You may access the entire act here.

Updates to the Tennessee Chronic Pain Guidelines

The Department is beginning to see ours, and others' policymaking efforts yield some exciting results and possibilities. Since the "Tennessee Chronic Pain Guidelines" were finalized in 2014, we have seen a 12.0% drop in the total number of morphine milligram equivalents prescribed in our state. Unfortunately, these drops have not reduced the number of overdose deaths in our state, which continue to rise year after year. In 2015, at least 1,451 Tennesseans died from prescription drug overdose, making overdose the leading cause of accidental death in our state. Instances of neonatal abstinence syndrome too, continue to rise.

The public chapter that required the creation of the "Chronic Pain Guidelines" also includes the requirement that the Guidelines be reviewed and amended as appropriate every September. The most recent review of the Guidelines included the following revisions:

- Recommends that treatment plans be developed at the onset of treatment and should include treatments or modalities beyond opioids, both non-pharmacological and pharmacological.
- Endorses the 3-item PEG Assessment Scale as an appropriate tool in establishing treatment goals with patients.
- Acknowledges that the risk of overdose for all patient populations increase tenfold at 100 MEDD, but may actually start closer to 81 MEDD.
- States that when opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days is sometime appropriate but should be documented in the medical record.
- Suggests that a primary care provider starting opioid therapy should generally prescribe immediate-release opioids instead of extended-release or long acting opioids. Acknowledges that deviations are expected and the reason(s) should be documented.
- Specifies that prescribers must not prescribe bupren-

Department of Health-Sponsored Controlled Substance Prescribing CME

More dates will be added in 2017

October 25 Jackson Madison General Hospital
November 3 West Park Professional Building
November 17 UT Erlanger Hospital
December 13 Pyramid Bass Pro Shop

Click **HERE** to register.

2016 End of Year Update for Prescribers

Continued from page 3

- Specifies that prescribers must not prescribe buprenorphine in off label use for chronic pain conditions and only certified pain specialists should prescribe on label buprenorphine products for chronic pain.
- Recommends that clinicians should offer or arrange evidence-based treatment for patients with opioid use disorder and referral to an addiction specialist as appropriate.
- Adopts the definition of "pain medicine specialist" set forth in Tenn. Code Ann. § 63-1-301.
- Includes in the appendix, a new section on non-opioid therapy and the "Tennessee Emergency Department Opioid Prescribing Guideline."

This list of revisions provided above is not exhaustive. You are encouraged to access the "Tennessee Chronic Pain Guidelines" from the Department of Health's website.

Controlled Substance Prescribing CME

If you are a prescriber with a DEA registration, you are legally required as a condition of your licensure, to complete a two hour course designed to address controlled substance prescribing and which includes instruction in the "Tennessee Chronic Pain Guidelines." The two hour course must be earned in the two calendar years preceding the year that you renew your license. For example, a physician who is scheduled to renew her license in 2017, should obtain these hours sometime between January 1, 2015 and December 31, 2016.

This requirement was statutorily enacted in 2014 and is codified at TENN. CODE ANN. § 63-1-402. If you are not a prescriber with a DEA, or if you are exempted from the prescribing course under section (c) of the statute, you should look to the continuing medical education rules of your profession to determine the requirement that applies to you.

While we do not endorse any particular course or courses (any course covering the statutorily prescribed content will be accepted), representatives from several prescribing boards have collaborated with medical programs and entities across the state to bring prescriber education to a city near you.

Legislative Changes Affecting Prescribers

Members of the Tennessee General Assembly have responded to the opioid and prescription drug crisis plaguing our state with new legislation year after year. Some legislation revises and refines existing law, while other legislation is entirely new and seeks to tackle new angles of this deadly epidemic. In addition to the Prescription Safety Act of 2016, the following public chapters may affect your prescribing and practice:

Public Chapter 912

Creates nonresidential office-based opiate treatment facilities. This legislation requires any facility that meets the definition of a nonresidential office-based opiate treatment facility to attain licensure as such by the Department of Mental Health & Substance Abuse Services. Nonresidential office-based opiate treatment facilities refers to facilities that are prescribing buprenorphine or products containing buprenorphine to 50% or more of its patients and to one hundred fifty patients or more. This legislation requires the TDMH&SAS to promulgate rules in consultation with the Department of Health and will take effect on January 1, 2017.

2016 End of Year Update for Prescribers

Continued from page 4

Public Chapter 1033

Requires that all pain management clinics in Tennessee be licensed by July 1, 2017. The public chapter sets forth a licensing framework and gives the Commissioner of Health the ability to designate a facility or office operating like a pain clinic as such for purpose of licensure and fine that entity for operating as a pain clinic without a license. The law allows for rolling registration of current pain clinics until the licensure process is complete but eliminates all pain clinic certificates.

Public Chapter 959

Authorizes the Commissioner of Health or the Commissioner's designee to obtain records maintained by any licensed facility to facilitate investigations and inquiries concerning opioid drug abuse, opioid drug overdoses, and opioid overdose deaths. Such facilities must provide records in the most efficient and expedient means possible. To determine these means, the department must:

- Consult with stakeholders to develop a long-term electronic real-time data reporting plan utilizing electronic processes for opioid drug abuse, overdoses and overdose deaths by January 1, 2017.

Public Chapter 829

Specifies that, on and after July 1, 2016, a new applicant seeking designation as a pain management specialist through board certification by the American Board of Interventional Pain Physicians (ABIPP), may only qualify by passing parts 1 and 2 of its examination, and holding an unencumbered Tennessee license, and maintaining the minimum number of CME hours in pain management to satisfy retention of ABIPP diplomate status.

Public Chapter 973

Establishes requirements for the dispensing of opioids and benzodiazepines by physicians and other healthcare providers. Those requirements are:

Dispenses opioids and benzodiazepines, as directed by the patient's prescription, in safety-sealed, prepackaged containers stamped with the manufacturer's national drug code (NOC) number.

Administers and records pill-counts for opioids or benzodiazepines in order to ensure patient compliance with the prescription.

Dispenses non-controlled substances which amount to at least fifty percent (50%) of the prescriptions filled annually from the practice.

Submits controlled substance dispensing information to the controlled substances monitoring database under title 53, chapter 10, part 3, according to the requirements of state law.

Building Better Federal Partnerships

The Tennessee Department of Health continues to maintain existing and create new federal partnerships that make our work stronger and our positive outcomes easier to duplicate. In June, the Department through the boards of medicine, worked to bring the US Surgeon General, Dr. Vivek Murthy, to Tennessee for grand rounds. In Nashville and Knoxville, Dr. Murthy spoke about his campaign to "Turn the Tide" on opioid addiction. In August, the Surgeon General followed up his tour through the US with a letter to all physicians urging them to become educated on how to treat pain safely and effectively; to screen patients for opioid use disorder and/or connect them with evidence-based treatment; and to treat addiction as a chronic illness and "not a moral failing." The Surgeon General's Office is like many other federal agencies that have responded to the issue of opioid abuse and dependence with significant policymaking. Please see below for additional resources from our federal partners:

CDC Guideline for Prescribing Opioids for Chronic Pain

"A Proactive Response to Prescription Opioid Abuse," Robert M. Califf, MD, Janet Woodcock, MD and Stephen Ostroff, MD, N Eng J Med 2016; 374: 1480-1485

US Surgeon General's Call to End the Opioid Crisis: "Turn the TideRX"

Opioid Prescribing Resources from the National Institute on Drug Abuse

HHS: "Opioids: The Prescription Drug & Heroin Overdose Epidemic"

FDA Opioid Action Plan

"Chasing the Dragon: The Life of an Opiate Addict" (documentary produced by FBI and DEA)

Board to Accept MOC Activities as Proof of Completion of CME

As a condition of continued licensure, all medical doctors are required to complete forty hours of CME in the two calendar years preceding the year of renewal. Accordingly, a licensee who is scheduled to renew his or her medical license in 2017 should earn all required CME credits between January 1, 2015 and December 31, 2016. Increasingly, physicians are licensed in multiple states and may even be participating in the maintenance of certification (MOC) process for more than one certifying body. Each state and certifying board has a different timeline for completion of these CME requirements, which can be very difficult for a busy physician to manage.

To simplify this process for its physician licensees, the Board recently took the position that a physician may comply with the CME requirements of the medical profession by providing proof that he or she is meeting the requirements of MOC for an American Board of Medical Specialties (ABMS) board. The physician is still required to earn two (2) credits in a prescribing course designed to address the "Tennessee Chronic Pain Guidelines;" however, the physician may meet the general education CME requirements by electing to have his or her MOC status verified by the Board's administrative staff.

In taking this position, the Board is not recommending or requiring board certification or maintenance of certification, rather the Board is allowing licensees who independently decide to participate in maintenance of certification to have their MOC activities counted not only toward their board certification but also toward the CME requirements for medical doctors in the state of Tennessee. This change will eliminate the need to submit CME certificates to the Board's administrative office, with the exception of the Tennessee-specific prescribing course. The Board hopes that this change will simplify the audit process for licensees. Virtually all of the 24ABMS boards require their diplomates to average more CME credit hours annually than what is currently required by the Tennessee Board of Medical Examiners.

Physicians are required to attest to their successful completion of all required CME at the time of their licensure renewal. In the first weeks of every month, a percentage of physicians who renewed their license in the preceding month are selected for audit. At that time, the auditee is asked to provide proof of completion of all requirements. Now, the notice of audit will allow a physician to specify whether he or she is currently participating in the MOC process for an ABMS board. An affirmative response will trigger the Board's administrative staff to verify successful participation MOC.

If You Need Help

The demands of the medical profession are high. It's important to remember to maintain your own well-being. Physicians suffering from mental, emotional or addictive challenges put their patients—and themselves—at risk of harm. If you suspect that you, or a member of your profession, has a chemical dependency or other psychological or physiological condition which impairs the practice of medicine, the Tennessee Medical Foundation can help. TMF administers Tennessee's Physician Health Program. The program offers consultation referral and monitoring for physicians whose practice is compromised by the use or drugs, alcohol or a psychological or physiological condition. You may self-report directly to TMF or you may make a confidential referral on behalf of a colleague or friend. Participation in the PHP is not an automatic trigger for disciplinary action and may not interrupt your medical practice.

Participation in the PHP does not trigger disciplinary action and may not interrupt your medical practice.

Please call (615) 467-6411 or visit https://e-tmf.org/ today for more information.

TN Department of Health

Tennessee Board of Medical Examiners
2nd Floor | 665 Mainstream Drive | Nashville, TN, 37206
T: 615-532-3202 | F: 615-253-4484 | tn.gov/health/topic/ME-board

Board Issues Policy to Clarify Position on International Medical School Admissions Criteria

In recent years, the Board has been asked with increasing frequency to interpret Tenn. Comp. R. & Regs. 0880-02-.04(3) and more specifically to determine whether a particular international medical school met or exceeded the Liaison Committee on Medical Education's (LCME) accreditation standards. A policy adopted by the Board in 2008 stated that all schools on the Medical Board of California's list of approved medical schools were presumed to meet the requirements of 0880-02-.04(3)(d) and all schools listed on the "disapproved" list were presumed not to comply with the requirements. The 2008 policy, did not, however, specify how to treat schools that were neither approved nor disapproved by California.

Since the promulgation of the rule and adoption of the policy, several reputable international accrediting organizations and authorities have emerged. The Board considered the rule, existing policy and new and existing authorities before adopting a new policy document: "Determinations of Standards for International Medical Schools and Graduates of Unapproved Foreign Medical Schools."

In essence the Board specified that the following accreditation bodies are presumed to comply with 0880-02-.04 (3)(d):

- Medical Board of California's list of approved medical schools;
- Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP); and
- Accreditation Commission of Colleges (ACCM)

Additionally, schools in countries which are recognized by the National Committee on Foreign Medical Education and Accreditation (NCFMEA) are presumed to meet or exceed LCME standards.

The policy is an important development that eliminates a barrier to licensure for many qualified applicants. You may access the full document here.

Members of the Board of Medical Examiners

Subhi D. Ali, MD	President	General Surgery	Middle Tennessee
W. Reeves Johnson, MD	Vice President	Family Practice	East Tennessee
Melanie Blake, MD	Secretary	Internal Medicine	East Tennessee
Michael J. Baron, MD	Member	Psychiatry	Middle Tennessee
Neal Beckford, MD	Member	Otolarynogology	West Tennessee
Deborah Christiansen, MD	Member	Pediatrician	East Tennessee
Julianne Cole	Member	Citizen member	East Tennessee
Patricia Eller	Member	Citizen member	East Tennessee
Dennis Higdon, MD	Member	Anesthesiology	West Tennessee
Clinton A. Musil, Jr., MD	Member	Pediatrician	East Tennessee
Barbara Outhier, MD	Member	Citizen member	Middle Tennessee
Michael Zanolli, MD	Member	Dermatologist	Middle Tennessee

The Watercooler

Where Board staff answer some of your most commonly asked questions...

You are selling your practice. What are your obligations to your patients?
Board Rule 0880-02-.15(3) addresses the sale of a medical practice.

Your significant other has a toothache and cannot see a dentist for another week. Can you write a prescription for pain medicine and an antibiotic?
The Board has a policy in place to address prescribing for oneself and one's family. Additionally, the AMA's Code of Medical Ethics, which the Board has adopted by rule, addresses treating oneself or one's family. These resources should guide licensees when making a decision about whether treatment is proper.

While Board staff may not provide legal advice or interpret the Board's rules or statutes on the Board's behalf, any licensee of the Board may submit a written request for an advisory ruling subject to certain limitations. The procedures for obtaining an advisory ruling are set forth at Rule 0880-02-.11(6).

TDH Spotlight: Zika Virus

The Tennessee Department of Health continues to closely monitor Zika virus within our borders and provide educational information to Zika-infected persons and at-risk persons in their communities. Local Transmission of Zika virus continues in Miami, Florida. Tennessee has had 53 cases, all due to travel to other countries. The TDH has announced two new recommendations, which are provided for you below:

Tennessee has had 53 cases of Zika virus, all due to travel to other countries.

- Men with possible Zika virus exposure, regardless of symptom status, should wait to conceive until at least 6 months after symptom onset, or last possible Zika virus exposure (if asymptomatic). Women with possible Zika virus exposure are recommended to wait to conceive until at least 8 weeks after symptom onset or last possible exposure.
- Infected pregnant women can have evidence of Zika virus in their blood for longer than previously thought, and even pregnant women without symptoms can have evidence of the virus in their blood and urine. Symptomatic and asymptomatic exposed pregnant women can undergo PCR testing up to 14 days after symptom onset or possible exposure. Beyond the 2 week time frame, symptomatic pregnant women should receive antibody tests for both Zika and dengue virus. Those without symptoms should undergo Zika antibody testing.

Extensive additional resources are available here.

TN Department of Health

Tennessee Board of Medical Examiners
Building, Floor | Address | Nashville, TN, ZIP
T: 615-837-5103 | F: 615-000-1234 | tn.gov/department

2016 Legislative Summary

The Tennessee Generally Assembly convenes for legislative business every January. Because the body's 90 legislative days are divided between the two years of its terms, the Generally Assembly adjourns in April of each year.

The Board of Medical Examiners is not a political entity, and does not customarily take positions on proposed legislation. Board members may engage in the legislative process, but they may do so only as private citizens.

The following laws were enacted in the 2016 session, which adjourned on April 22, 2016. The 110th General Assembly will reconvene on January 10, 2017.

Public Chapter 912

As enacted, creates nonresidential office-based opiate treatment facilities. This legislation would require any facility that meets the definition of a nonresidential office-based opiate treatment facility to attain licensure as such by the Department of Mental Health & Substance Abuse Services. Nonresidential office-based opiate treatment facilities refers to facilities that are prescribing buprenorphine or products containing buprenorphine to 50% or more of its patients and to one hundred fifty patients or more. This legislation would require the TDMH&SAS to promulgate rules in consultation with the Department of Health. This act will take effect on January 1, 2017.

Public Chapter 1033

This act requires that all pain management clinics in Tennessee be licensed by July 1, 2017. The bill sets forth a licensing framework and gives the Commissioner of Health the ability to designate a facility or office operating like a pain clinic as such for purpose of licensure and fine that entity for operating as a pain clinic without a license. The bill allows for rolling registration of current pain clinics until the licensure process is complete.

Public Chapter 763

Permits licensees whose licenses have expired due to non-payment to obtain reinstatement when payment of past due renewal fees, which are capped at twice the annual renewal fee, and unattained continuing education are completed. This replaces the current requirement of payment of all past due fees before reinstatement. This act will take effect on July 1, 2016.

Public Chapter 1035

This act revises provisions relating to the qualifications of an applicant for a license to practice medicine. Specifically, this legislation:

Authorizes individuals who completed a primary specialty training program accredited by the Royal College of Physicians and Surgeons of Canada, which is of duration of at least four years, to apply with the Department of Health for a specialty training license in order to practice such specialty in Tennessee.

Expands, from seven to ten years, the duration of time in which an individual seeking a specialty license to practice medicine or surgery in Tennessee has to complete the United States Medical Licensing Examination or its successor examination, from the time the applicant successfully completes the first step in the examination.

Authorizes the Board of Medical Examiners to issue a temporary license of limited duration to an international medical school graduate with demonstrated competence, in the discretion of the Board as special circumstances require.

Authorizes the Board of Medical Examiners to issue limited licenses to physicians who have been out of clinical practice for an extended period of time or who have been, or are at the time of their application, engaged exclusively in administrative medicine.

The Board of Medical Examiners may promulgate rules to effectuate any of these law changes. Any rule promulgated must also be sent to the Chairs of the Senate and House Health Committees when they are sent to the Government Operations Committee.

This legislation became effective on April 28, 2016.

Public Chapter 540

As enacted, extends the board of medical examiners four years to June 30, 2020.

Public Chapter 942

This public chapter authorizes a pharmacist to provide hormonal contraceptives according to a valid collaborative

Continued on page 10

2016 Legislative Summary, Cont'd

Continued from page 9

pharmacy practice agreement containing a non-patient specific prescriptive order and standardized procedures developed and executed by one of more authorized prescribers. Under such circumstances, the pharmacist may provide hormonal contraceptives to individuals who are: (1) 18 years of age or older; or (2) Under 18 years of age, if the individual is an emancipated minor. This act took effect on April 27, 2016.

Public Chapter 951

PC 951 removes the provision whereby a person who provides prayer in lieu of medical or surgical treatment could not be charged with the crime of child abuse, neglect, or endangerment solely for that reason. This act will take effect on July 1, 2016.

Public Chapter 956

As enacted, this replaces the present law requirement that individual physician's offices and practices register as medical spas, with a requirement that any physician-owned practice that advertises or holds itself out as a medical spa or a physician-owned practice that primarily engages in the performance of elective cosmetic medical services must register as a medical spa. This legislation further changes the deadline for submitting information related to registering as a medical spa from January 1, 2016, to January 1, 2017. This took effect on April 27, 2016.

Public Chapter 959

This bill authorizes the commissioner of health or the commissioner's designee to obtain records maintained by any licensed facility licensed to facilitate investigations and inquiries concerning opioid drug abuse, opioid drug overdoses, and opioid overdose deaths. Such facilities must provide records in the most efficient and expedient means possible. To determine these means, the department must:

Consult with stakeholders to develop data reporting elements and a short term mechanism for near real-time electronic access to these date elements by July 1, 2016.

Implement the short-term reporting system by October 1, 2016.

Consult with stakeholders to develop a long-term electronic real-time data reporting plan utilizing electronic processes for opioid drug abuse, overdoses, and overdose deaths by January 1, 2017.

This legislation took effect on April 27, 2016.

Public Chapter 632

Present law exempts medical interns, residents, and fellows from licensure requirements for physicians when such persons are participating in a training program of one of the accredited medical schools or of one of its affiliated teaching hospitals in Tennessee, performing duties assigned to meet the requirements of such program, and while under the supervision and control of a licensed physician. Similarly, present law exempts osteopathic medical interns, residents, and clinical fellows from licensure requirements for osteopathic physicians while participating in a training program approved by the American osteopathic association or the American medical association, performing duties assigned to meet the requirements of such a program and while under the supervision and control of a licensed physician. This legislation extends the exemption from licensure for training to osteopathic medical students and medical students under the same conditions as presently apply to osteopathic medical interns, residents, and clinical fellows and medical interns, residents, and fellows. It specifies that it is the responsibility of the program director or the dean responsible for a training program to apply to the board of osteopathic examination for an exemption for each medical student, in addition to each medical intern, resident, or clinical fellow. This legislation takes effect on July 1, 2016.

Public Chapter 1046

Creates a 21-member task force to study issues related to healthcare services; specifies that the task force will make a report and cease to exist by January 15, 2017. The composition of the task force will be:

The speaker of the house of representatives will appoint:

(1) Two members of the house of representatives;

(2) Two practicing physicians, one of which shall be an anesthesiologist;

(3) Two advance practice registered nurses, including one

2016 Legislative Summary, Cont'd

Continued from page 10

certified nurse practitioner and one certified registered nurse anesthetist;
(4) One representative of a doctor of nursing program;
(5) One representative of a school of medicine program; and
(6) One representative of municipal government.

The speaker of the senate will appoint:
(1) Two members of the senate;
(2) Two practicing physicians;
(3) Two advance practice registered nurses, including one certified nurse practitioner and one certified nurse midwife;
(4) One representative of a doctor of nursing program;
(5) One representative of a school of medicine; and
(6) One representative of county government.

The commissioner of health will appoint one representative of the department of health.

The task force will be required to develop a plan to educate the public and health care professionals about the advantages and methods for a "transformative", rather than "transformed" health care delivery system that addresses the need for accessible, equitable, and affordable care provided by the appropriate healthcare professional. This amendment adds a requirement that the task force develop potential public policy options to address any barriers to the adoption of best practices. The first meeting of the task force shall be convened by a senator who is appointed to serve on the task force. The task force must make its report and cease to exist by January 10, 2017.

This act took effect on April 28, 2016.

Public Chapter 766

This bill permits charitable clinics to contract with or employ dentists, physicians, psychologists, optometrists, and osteopathic physicians. It requires the contractual relationship between a healthcare provider and a charitable clinic to be in a written contract, job description, or documentation, containing language that does not restrict the healthcare provider from exercising independent professional judgment in diagnosing and treating patients. It does not authorize a charitable clinic to employ an anesthesiologist, an emergency department physician, a pathologist, or a radiologist, or an osteopathic physician who specializes in any such type of medicine. This bill took effect on April 19, 2016.

Public Chapter 805

This act authorizes a health care prescriber to prescribe epinephrine auto-injectors in the name of an authorized entity. It authorizes pharmacists and health care prescribers to dispense epinephrine auto-injectors pursuant to a prescription issued in the name of an authorized entity. This becomes effective on July 1, 2016.

Public Chapter 829

Specifies that, on and after July 1, 2016, a new applicant seeking designation as a pain management specialist through board certification by the American Board of Interventional Pain Physicians (ABIPP), may only qualify by passing parts 1 and 2 of its examination, and holding an unencumbered Tennessee license, and maintaining the minimum number of CME hours in pain management to satisfy retention of ABIPP diplomate status. This took effect on April 21, 2016.

Public Chapter 973

This act establishes requirements for the dispensing of opioids and benzodiazepines by physicians and other healthcare providers. Those requirements are:

Dispenses opioids and benzodiazepines, as directed by the patient's prescription, in safety-sealed, prepackaged containers stamped with the manufacturer's national drug code (NOC) number.

Administers and records pill-counts for opioids or benzodiazepines in order to ensure patient compliance with the prescription.

Dispenses non-controlled substances which amount to at least fifty percent (50%) of the prescriptions filled annually from the practice.

Submits controlled substance dispensing information to the controlled substances monitoring database under title 53, chapter 10, part 3, according to the requirements of state law.

Public Chapter 678

This act establishes a stroke best practices and treatment guidelines task force under the department of health. The task force will consist of:

A designated member from each comprehensive stroke center in the state;

A designated member from a primary stroke center;

A designated member from an acute stroke ready hospital;

Three emergency medical service (EMS) representatives, to include representatives of a rural area, an urban area, and the Tennessee ambulance service association;

A representative of an emergency communications district board;

Appropriate staff from the department of health;

A representative of the Tennessee medical association; and

A representative of a nationally recognized stroke association with a stroke data collection platform system.

This act took effect on March 29, 2016. The task force will sunset on June 30, 2021.

Public Chapter 625

This legislation requires healthcare providers to provide women at risk of contracting cytomegalovirus (CMV) with information concerning CMV and specifies that there is no liability for failure to comply with the requirement to provide the information. This act will take effect on July 1, 2016.

Public Chapter 986

This legislation clarifies that the consent required of a woman in order for medical experiments, research, or the taking of photographs upon her aborted fetus must be in writing. This act will take effect on July 1, 2016.

Public Chapter 987

Requires hospitals, coroners, and medical examiners to report cases of maternal mortality to the department of health and requires the department to provide data on maternal mortality on its web site. This act will take effect on July 1, 2016.

Public Chapter 989

This legislation authorizes a parent of a newborn to object and opt out of treatment to the newborn's eyes to prevent certain conditions and removes the Class C misdemeanor penalty for a physician, nurse, or midwife who fails to administer the treatment. This act will take effect on July 1, 2016.

Public Chapter 990

This legislation requires an insurer to reimburse and provide coverage for telehealth services provided by a practitioner licensed in Tennessee, regardless of the patient's location. This act will take effect on January 1, 2017.

Public Chapter 1002

Public Chapter 1002 enacts the "Tennessee Prescription Safety Act of 2016," which revises regulation of controlled substances primarily by means of procedures involving the controlled substances database. This act was effective upon the Governor's signature on April 27, 2016. The new act has four major highlights.

Removes the sunset from the Prescription Safety Act of 2012 making the act permanent.

Creates an operations committee to provide a check and balance the commissioner of health's rulemaking authority.

Requires that a dispenser shall check the database when dispensing a controlled substance to a new patient or once a year to a known patient on a maintenance medication.

Creates a professional duty to check the database before prescribing to someone exhibiting drug seeking behavior.

Public Chapter 1003

This legislation establishes requirements regarding the disposition of fetal remains resulting from surgical abortions, including reporting requirements and requirements for interim inspections of and certain reporting by facilities where surgical abortions are performed. This act took effect on April 27, 2016.